621 Water Street
Santa Cruz, CA 95060
Office: 831-457-2848   Fax: 831-457-1407

Welcome to our office

Checks and cash are accepted for payment. Payment is due at the time of your visit. I will provide you with a "superbill" receipt that can be submitted to your insurance provider for reimbursement.

Confidential

Name:____Date of birth:________________Age:_________

Address:____

City,zip:____

Phone:H______________________W_________________________C___________________________

email address:____

Occupation:____

Contact in case of emergency:____

How did you hear about me?____

What is (are) the reason(s) for your visit today?____

____

____

Cancellation Policy: Kindly give 24 hours notice of cancellation, at which time I can easily reschedule your appointment. You are expected to pay for the time set aside for you in case of a missed appointment, except for emergencies. I have read and understand my responsibility for payment of services.

Signature_____________________________________**Date**__________________________________

Are you currently under the care of a Medical Doctor?__________Date of last visit:_______________

Name of MD:____

Doctor's nurse:______________________________________Phone:(if you have it)________________

Are you currently seeing any other health care providers? If yes, please list the name and type of provider:____

____

Have you ever been treated with Acupuncture or Chinese Medicine?_______________________________

____

Please list the names of medications/vitamins/minerals/herbs you are currently taking:

____

____

____

____

Please list any allergies to food or medications:

____

____

Please list any surgeries you have had and the date:____

____

____

____

Circle if you have experienced any of the following:

adverse reactions to medical treatment
allergies
asthma
anemia
arthritis
artificial heart valves or joints
bleeding disorder
blood disease
cancer or tumor
chemical dependency
diabetes
eating disorders
eye disorders
gout
headaches
heart disease
hemophilia
kidney disorder
low blood pressure
musculo-skeletal disorder
organ transplant
pace maker
respiratory disorder
rheumatic fever
sciatica
seizures/epilepsy
sexually transmitted disease
skin problems
stomach or intestinal disorder
stroke
thyroid disorder
transfusion
tuberculosis
ulcer

hepatitis, Jaundice, liver disorder

herpes 1,2

high blood pressure

immune disorder

urinary tract infection

other____________________

____

____

Pain

If you have pain, list the areas affected:____

____

____

____

What date did the pain begin?____

Was there an injury or trauma that initiated the pain?____

____

What is the severity of pain today? 0 1 2 3 4 5 6 7 8 9 10

Do you exercise?________________________What type and how often?______________________

____

____

Gastrointestinal

Please describe any digestion problem:____

____

Foods and beverages that worsen the condition:____

____

____

Do you notice if the problem is worse on a full or empty stomach?__________________________________

Describe your usual diet, including how many meals or snacks per day? ___________________________

____

____

____

Please circle which applies:

constipation, loose stool, blood in stool, painful, grey color, urgency, foul smell,

Do you have a bowel movement daily?____

Do you often wake to during the night to urinate?_____________How many times?_____________

Is there any difficulty with urination?____

____

Sleep

Do you sleep well?_______________________Fall asleep easily?_____________________________

Wake up often during the night?___________How many hours of sleep do you get?____________

Describe your general mood____